SERFF Tracking Number:	*MHPL-126293991*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*43425*
Company Tracking Number:	*INDIVAPP2010*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*INDIVAPP2010*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Mercy Health Plans

Product Name: INDIVAPP2010	SERFF Tr Num: MHPL-126293991	State: Arkansas
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 43425
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num: INDIVAPP2010	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Karen Hosack	Disposition Date: 09/09/2009
	Date Submitted: 09/04/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 09/09/2009	Explanation for Other Group Market Type:
	State Status Changed: 09/09/2009
Deemer Date:	Created By: Karen Hosack
Submitted By: Karen Hosack	Corresponding Filing Tracking Number:

Filing Description:

Ms. Rosalind Minor
Senior Certified Rate and Form Analyst
Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

SERFF Tracking Number:	*MHPL-126293991*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*43425*
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Product Name:	*INDIVAPP2010*		
Project Name/Number:	*/*		

RE: PHI AR INDIV APP/LT (2010), et al.
NAIC: 11529

Dear Ms. Minor:

I am submitting these documents for your review and approval along with the required Policy Form Compliance Certification and a filing fee of $50. These documents are for an individual comprehensive major medical PPO product.

The Application has been revised and a redlined copy of the substantive changes is attached for convenience. The Secondary Health Questionnaire was also revised, however the changes were considerable and a redlined copy would only be confusing. The changes to the Secondary Health Questionnaire primarily included adding questions and fields for surgery dates and adding clarifying questions about certain diagnoses that were already listed on the form. This Individual Application and Secondary Health Questionnaire replace the following:

FORM NUMBER	DESCRIPTION	DATE APPROVED
PHI AR INDIV/HQ (2008)	Individual Health Questionnaire	1/23/2008
PHI AR INDIV APP/ LT(01/08)	Application for Individual Comprehensive Health Coverage	1/23/2008

Please note that there have been no changes in rates since the original Rate Filing approved on 8/8/2007.

The Hearing Aids Services Rider and Election Form are new and do not replace any previous documents. The Hearing Aid Services Rider is in compliance with Arkansas mandate and Bulletin 7-2009. The Election Form will be used strictly for renewals, since new applicants will be able to elect/decline this mandated offer on the Application itself.

The Replacement Notice is also new and does not replace any previous document. This notice is in compliance with AR Rule and Regulation 18 s. 9.

Please contact me at (314) 214-2342 or by email at khosack@mhp.mercy.net if you have any questions.

Sincerely,
Karen Hosack, MHP, CCP
Compliance Analyst

Company and Contact

Filing Contact Information

Karen Hosack, Compliance Analyst khosack@mhp.mercy.net

SERFF Tracking Number:	*MHPL-126293991*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*43425*
Company Tracking Number:	*INDIVAPP2010*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*INDIVAPP2010*		
Project Name/Number:	*/*		

Mercy Health Plans
14528 South Outer Forty Rd.
Suite 300
Chesterfield, MO 63017

314-214-2342 [Phone]
314-214-8103 [FAX]

Filing Company Information

Mercy Health Plans
14528 South Outer Forty Rd.
Suite 300
Chesterfield, MO 63017
(314) 214-8100 ext. [Phone]

CoCode: 11529
Group Code:
Group Name:
FEIN Number: 48-1262342

State of Domicile: Missouri
Company Type: LAH/PPO
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	Form filing
Per Company:	No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
202901	$50.00	09/03/2009

SERFF Tracking Number:	*MHPL-126293991*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*43425*
Company Tracking Number:	*INDIVAPP2010*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*INDIVAPP2010*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor (FM)	09/09/2009	09/09/2009

SERFF Tracking Number:	*MHPL-126293991*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*43425*
Company Tracking Number:	*INDIVAPP2010*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*INDIVAPP2010*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 09/09/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MHPL-126293991*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*43425*
Company Tracking Number:	*INDIVAPP2010*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*INDIVAPP2010*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Redlined Copy	Approved-Closed	Yes
Form	Individual Application Form	Approved-Closed	Yes
Form	Replacement Notice	Approved-Closed	Yes
Form	Individual Hearing Aid Services Rider	Approved-Closed	Yes
Form	Individual Election Form for Hearing Aid Services	Approved-Closed	Yes

SERFF Tracking Number:	*MHPL-126293991*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*43425*
Company Tracking Number:	*INDIVAPP2010*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*INDIVAPP2010*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/09/2009	PHI AR INDIV APP/LT (2010)	Application/ Enrollment Form	Individual Application Form	Initial			AR Individual Application 2010 _9.3.09.pdf
Approved-Closed 09/09/2009	PHI AR APP/SUPP (10-09)	Application/ Enrollment Form	Replacement Notice	Initial			REPLACEMENT NOTICE.pdf
Approved-Closed 09/09/2009	PHI AR INDIV RDR/HA (2010)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Individual Hearing Aid Services Rider	Initial			AR Individual Hearing Aid Rider.pdf
Approved-Closed 09/09/2009	PHI AR INDIV CVR/HA-08-09	Application/ Enrollment Form	Individual Election Form for Hearing Aid Services	Initial			AR INDIV Hearing Aid Rider Election Form_OFFER .pdf

Mercy*One* Application Checklist

Please follow this checklist to ensure your application is complete and avoid unnecessary underwriting delays.

- ❑ Complete the General Member Information section (page *). Include the name, gender, height, weight, social security number, and date of birth for every person applying for coverage.

- ❑ Request an effective date on (page *). You may select either the [1st] or [1st and/or 15th] of the month.

- ❑ Obtain and send to Mercy Health Plans a copy of any Certificate of Creditable Coverage, if you have had prior health insurance coverage through another carrier. We will need a copy of this Certificate in order to grant you a waiver for any pre-existing conditions.

- ❑ Select the plan option for which you will be applying (page *).

- ❑ Answer all Health History questions (page * and *). Also, list all prescriptions and over-the-counter medications taken for each person applying for coverage. Failure to answer these questions will delay the underwriting of your application.

- ❑ Give us complete details in the attached *Secondary Health Questionnaire*, if you answered "yes" to any Health History conditions listed on page * (question # 6). The page number(s) listed next to the condition(s) in this section refer to corresponding questions in the *Secondary Health Questionnaire*.

- ❑ List the primary care physician, phone number, and date of last visit for each person applying for coverage (page*).

- ❑ Initial and date the Statements of Understanding (page *).

- ❑ Sign and date the Authorization to Use and Disclose Protected Health Information (page*). This applies to each enrolling Applicant age 18 or over. If your application is dated more than 60 days before the requested effective date, you will be asked to re-apply.

- ❑ Complete the Payment Information (page *). Payment for this policy can be made by automatic withdrawal from a checking or savings account. Mercy Health Plans also accepts Visa, MasterCard or American Express credit card payments [(plus a 2% administration fee)]. All payment options are withdrawn on a monthly basis on or about the [15th] [day] of the month.

If you need assistance in completing your application, please contact your agent. If you do not have an agent, please contact the Mercy*One* Sales Department (501) 372-0065 or (800) 330-8293, or email: *mercyonearkansas@mercy.net*.

Mercy Health Plans
521 President Clinton Avenue • Suite 700
Little Rock, AR 72201
(501) 372-0065 • 800-330-8293
www.mercyhealthplans.com

Individual Application for Comprehensive Health Insurance

Please complete in black only.

Application Type

Coverage Information (Select One): ☐ New Coverage _____ Effective Date Requested: ____/____/____

☐ Change to current plan Member Number: _____ Effective Date of Change: ____/____/____

☐ Add dependent (s) to current coverage Member Number: _____ Effective Date of Change: ____/____/____

Applicant Information

Please enter the following applicant information: (If applying for *Child Only* Coverage, record the child's information in the following section. Please submit a separate application for each Child Only Applicant.)

NAME: First Middle Last | Subscriber's Occupation:

HOME ADDRESS: (Street & P.O. Box if applicable) City State Zip County

Home Phone: (_____) _____ Best time to call: ☐ Day ☐ Evening | E-mail (this will not be shared with a 3rd party): _____

Work Phone: (_____) _____ Cell Phone #: (_____)_____

Are you a United States citizen? ☐ Yes ☐ No
If "No", do you possess a Green Card (Permanent Resident Card) or a temporary U.S. visa? ☐ Yes ☐ No If "No", please explain: _____

Are you a legal resident of the state of Arkansas? ☐ Yes ☐ No If "No", please explain: _____

Have you resided in the United States for the past six (6) consecutive months? ☐ Yes ☐ No

General Member Information

Please complete information below for all family members applying for coverage (attach other pages, if needed).

Name First	MI	Last	Relationship to Applicant	Sex M/F	Height Ft.	In.	Weight lbs.	SSN#	Date of Birth (mm/dd/yyyy)
			Self						
			Spouse						
			Child						
			Child						
			Child						
			Child						
			Child						

Will the Mercy Health Plans' coverage that you are applying for **replace** or **change** your current hospital, medical or major medical insurance? ☐ Yes ☐ No

Will any applicants be **continuing** any other health insurance? ☐ Yes ☐ No If 'Yes', list name(s) : _____

Producer Information

If you have a Producer (Broker or Agent) that will be assigned to your account, HAVE HIM/HER COMPLETE THIS SECTION.
Note: Mercy Health Plans (MHP) may share medical information with the Producer concerning you or your covered dependents that is contained in this application or discovered in the course of processing the application. The writing (and any assisting) Producer's current Arkansas health insurance license must be on file with MHP prior to acceptance of this application.

Do you know of any significant medical information relating to the applicant or any of his dependents that has not been reported on this form?
Yes ☐ No ☐

For purposes of processing commission, please provide the following information*:

Agency Name: _____ Broker's Name: _____

Broker's Telephone # : _____ Broker's Email: _____

Broker's Signature: _____ Date: _____

Notification: Broker Only ☐ (Broker to receive policy)
Broker and Subscriber ☐ (Member to receive policy, Broker to receive copy by email)

* Please fill out this information as it appears on your W-9 form.

Coverage and Benefit Selection

To choose the type of coverage that you would like, select ONE option from EACH of the sections numbered 1, 2, 3 and 4 below.

1) TYPE OF COVERAGE: ☐ Applicant only (Ages 19-65 yrs.) ☐ Child Only (Age 6 mos -18 yrs) ☐ Applicant & spouse
☐ Applicant & unmarried children* ☐ Applicant, spouse & unmarried children*

**Unmarried children under age 19, or who are full time students (FTS) through the date on which they turn 23 may be added to the plan. FTS documentation must accompany application. Call us for details on FTS documentation at [(501) 372-0065] [or] [800-330-8293].*

2) EFFECTIVE DATE REQUESTED: ____/____/____ [1st of the month only] [1st and 15th of the month only]
Note: The actual effective date will be determined by Mercy Health Plans, and if approved, you will be notified of the effective date for your policy.

3) OPTIONAL RIDERS:

Family Services Rider [(tubal ligations & vasectomies)] – Additional $____ /month (per family) (Applies only to Applicant and enrolled spouse) ☐ Yes ☐ No

Temporomandibular Joint Disorder (TMJ) Rider – Additional $ ____ /month/per applicant ☐ Yes ☐ No

Hearing Aid Services Rider – Additional $ ____ /month/per applicant ☐ Yes ☐ No

4) PLAN SELECTION: Traditional Plan Option – Choose ONLY ONE Plan option

Note: Maternity benefits apply only to the applicant or applicant's spouse, and will not begin until after you have been covered for 12 months. You must be over 19 years of age to elect maternity benefits.

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit PCP/Specialist	Coinsurance In-network/Out-of-Network	Prescription Copays
☐ ARK-A	12 month	No	$1,000	$2,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-B	12 month	No	$2,500	$5,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-C	12 month	No	$5,000	$10,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-AA	12 month	Yes	$1,000	$2,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-BB	12 month	Yes	$2,500	$5,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-CC	12 month	Yes	$5,000	$10,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-D	12 month	No	$500	$1,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-E	12 month	No	$1,000	$2,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-F	12 month	No	$2,500	$5,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-G	12 month	No	$5,000	$10,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-DD	12 month	Yes	$500	$1,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-EE	12 month	Yes	$1,000	$2,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-FF	12 month	Yes	$2,500	$5,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-GG	12 month	Yes	$5,000	$10,000	$15/$35	80/60%	$10/$40/$65/$100

Other Health Coverage

Answer "Yes" or "No" and list and/or submit additional information as requested below.

	Yes	No
1) Are you or anyone that is applying for coverage currently eligible for Medicare? If "yes", please list name(s):_____ _____ Note: Anyone who is eligible for Medicare is not eligible for coverage under this Policy.	☐	☐
2) Have you ever had your coverage through Mercy Health Plans terminated for failure to pay premiums? If "yes", please list name(s): _____ If your coverage was terminated by Mercy Health Plans for non-payment of premiums, you must wait 12 months before applying for coverage and one month's advance premium may be required.	☐	☐
3) Did you and/or your spouse and/or your eligible dependents have creditable coverage from a health insurance carrier within the past 63 days? (Creditable Coverage is any health insurance except a short term policy) If "yes", you may be eligible for pre-existing credit. If applicable, submit a copy of the Certificate of Creditable Coverage for each person applying.	☐	☐

Lifestyle

Answer "Yes" or "No" to the questions below.

	Yes	No
1) Have you or any family member(s) who are applying for coverage smoked tobacco within the last 12 months? If "yes", please list name(s):_____ Note: Additional testing may be required to confirm this information.	☐	☐
2) Have you or any family member(s) who are applying for coverage used other smokeless tobacco products within the last 12 months? If "yes", list name(s): _____ Note: Additional testing may be required to confirm this information.	☐	☐
3) Do you use alcohol or illicit drugs? If 'Yes', which do you drink/use? ☐ Alcohol ☐ Illicit drugs ☐ Both alcohol and drugs If 'Yes', how often do you drink/use? ☐ Seldom ☐ Occasionally ☐ Daily	☐	☐
4) Have you used alcohol or illicit drugs in the past? If 'Yes', when did you stop using them? ____/_____(mm/yyyy)	☐	☐

Health History

Answer "Yes" or "No" to the questions below.

	Yes	No
1) Is any proposed insured currently pregnant, an expectant parent, or in the process of adoption or surrogate pregnancy? Note: You are not eligible for coverage if you are a male or female expectant parent	☐	☐
2) Do you or any family member(s) who are applying for coverage have any pain, complaints or health conditions that a reasonably prudent person would anticipate requiring future medical treatment or surgery? If so, what are those health conditions, and what treatments are considered? (Attach other pages if needed)	☐	☐

_____
_____
_____

	Yes	No
3) In the last ten years have you or any family member(s) who are applying for coverage had any pain, complaints, symptoms, diagnoses or treatments of any disease, disorder or injury, or had any test results that you were told were abnormal or needed further evaluation?	☐	☐

If so, what are those conditions, disease states, injuries or abnormal test results? (Attach other pages if needed)

Yes	No
☐	☐

4) Are you or any family member(s) applying for coverage taking or have taken any drugs (including any over-the-counter drugs) or products during the past five (5) years?

If 'Yes', please list below:

- All prescription medication or over-the-counter drugs or products that are taken;
- All medication that you have been advised to take but have not;
- The person for whom each drug is prescribed;
- The prescribing physician, and
- The conditions that the drugs are prescribed to treat (attach other pages, if needed). It is important to note that if you are taking any prescribed medication, you should answer "Yes" to one or more of the questions relating to organ systems/diseases in question # (6) below.

Name of Drug	Dosage Amt (e.g. 100 mg/daily)	Refill Frequency	Person Drug Prescribed For	Prescribing Physician	Condition Drug Prescribed to Treat

5) List Primary Care Physician, phone number and date of last visit for each person applying:

Name of Applicant:	Primary physician name, phone number, city & state:	Date of last visit:

6) Do you or any family member(s) applying for coverage currently have or have ever been diagnosed or treated for any health conditions or diseases (either Inpatient, Outpatient or Emergency Room) pertaining to the following organ systems or diseases?	Yes	No
	☐	☐

Check "Yes" or "No" for all conditions listed below as they apply for any covered family member.

NOTE: If you answer "Yes" to any of these screening questions, you must also answer the ***Secondary Health Questionnaire*** related to those conditions. The page numbers listed below refer to related questions in the attached *Secondary Health Questionnaire*.

Yes	No		Yes	No	
☐	☐	1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes, [pg *]	☐	☐	10. Nervous System/Brain Disorder/Headache/Epilepsy/Seizure Disorder, [pg*]
☐	☐	2. Endocrine/Thyroid/Pituitary/Adrenal, [pg *]	☐	☐	11. Mental or Psychiatric Condition/Depression/Behavioral (e.g., Attention-Deficit Hyperactivity Disorder)or Eating Disorder, [pg*]
☐	☐	3. High Blood Pressure/Hypertension, [pg *]	☐	☐	12. Back or Neck Disorder/Lumbago/Disc Herniation or Protrusion/Sciatica/Sacroiliac Disorder, [pg *]
☐	☐	4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol, [pgs *]	☐	☐	13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disorder/TMJ, [pgs *]
☐	☐	5. Respiratory/Lung/Asthma/Allergies/TB/COPD, [pg *]	☐	☐	14. Muscular Disorder/Lupus/Connective Tissue Disorder/Auto-Immune Disorder, [pg *]
☐	☐	6. Ears/Eyes/Nose/Throat/Skin Disorder, [pg *]	☐	☐	15. Cancers/Tumors/Cysts/Neoplasms, [pgs *]
☐	☐	7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/ Polyps/ Hepatitis/Cirrhosis [pgs *]	☐	☐	16. HIV/AIDS/ARC/Chronic or Infectious Disease, [pg *]
☐	☐	8. Prostate/Reproductive Organ Disorder/Infertility/STD, [pg *]	☐	☐	17. Any Other Illness, Disease or Injury, [pg *]
☐	☐	9. Urinary Tract/Kidney or Renal Disease, [pg *]	☐		

Statements of Understanding

Please read all statements below, initial and date the bottom of this page.

1. I understand that this is an application only, and I should not cancel any coverage that I currently have until I am notified of acceptance for coverage by Mercy Health Plans (MHP).

2. I understand that I will receive either an acceptance, premium adjustment or denial from MHP, or a letter explaining the reason for the delay, within 60 days of MHP's receipt of this application. Note that If accepted, [you will be required to sign and return the letter of acceptance that we will send to you][you will automatically be enrolled and your Policy will be mailed to you in the timeframe stated above].

3. I understand that if the bank returns any payments due to insufficient funds, I will be assessed a fee. Additionally, I understand that if my premiums are not paid within the billing grace period, my coverage will be terminated as to the date when my premiums were paid in full. If my coverage is terminated, I will be unable to reapply for an Individual policy with Mercy Health Plans for one year.

4. I understand that if a Producer (Agent or Broker) is handling my request, the agent is not authorized to waive a complete answer to any question, make a decision as to insurability, make or alter any contract or waive any other rights or requirements of Mercy Health Plans.

5. I understand that if I or any covered family members am/are accepted for medical coverage, any pre-existing medical and/or mental health condition disclosed within this application will not be covered for up to 12 months after my effective date. (Credit may be given for prior creditable coverage upon receipt of certificate of creditable coverage.)

6. I understand that if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits will be withheld for 12 months for that condition or the coverage may be rescinded in its entirety at MHP's discretion.

7. I understand that I or any of my covered family members may need to obtain a physical examination at my own expense and submit the results as part of my application for coverage, if such an examination has not been performed within the last two years.

8. I understand that I or any of my covered family members have an obligation to notify Mercy Health Plans if we become aware of any medical conditions/injuries/disease states that would cause a reasonably prudent person to seek or require medical attention, from the time this application is signed to before the effective date of coverage. In this situation, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change.

9. I understand that if I purchase maternity benefits, they apply only to my spouse or me and do not begin until we have been covered for 12 months under the plan that includes the maternity benefit. Maternity benefits are not available for our dependent children and do not apply to child only plans.

10. I understand and agree that Mercy Health Plans may obtain or request information needed to process this application from me, my physician(s) and medical or pharmaceutical databases. A Mercy Health Plans' employee will then review this information. Any and all additions or corrections will then become part of the application. I understand that Mercy Health Plans will rely on this form and any information received to issue coverage.

11. I understand that if I omit or falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation of this coverage based on the terms of the policy. I agree to promptly repay any benefit payment(s) to which my covered family member(s) and/or I were not entitled.

12. I understand and agree that other health insurance coverage that I have might reduce my benefits under this Policy.

Please note:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Authorization to Use and Disclose Protected Health Information

NOTE: It is required that this *Authorization to Use and Disclose Protected Health Information* be completed and submitted with the application. The application is not complete without this authorization form.

Each person age 18 or over who is to be covered by this policy must sign at the bottom of this form.

I authorize Mercy Health Plans (MHP) or its affiliates to obtain necessary individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports from physicians, hospitals or other health care providers pertaining to my care or the care of any other dependent(s) listed on the application for insurance. I understand that this information can be used to determine my/our eligibility for insurance, and that those records can be requested as far back as the past ten years.

I authorize MHP to share necessary information with my Producer (Broker or Agent). I understand that Mercy Health Plans may disclose individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports to other entities in the course of its business operations or as required or permitted by law or as set out in the Mercy Health Plans Notice of Privacy Practices and authorize such disclosure. Federal regulations require that we inform you that under certain limited circumstances (e.g., judicial subpoena, state health department, etc.) the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by such regulation.

This authorization is valid for the duration of my coverage with Mercy Health Plans. I understand that this authorization is voluntary and that I may revoke this authorization at any time; however, if I do so before I am enrolled in the policy(ies), my application for coverage may be denied. A revocation request must be sent to MHP in writing to our home address, or via e-mail. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

By signing, I agree that I have fully read this entire application, including all seven pages of the Secondary Health Questionnaire, and I understand and agree with all statements contained herein. I also certify that I have answered all questions on the application and Secondary Health Questionnaire completely and accurately. I understand and agree to the release of information for the purpose(s) described above in this document.

All listed applicants 18 years of age and older must agree to the terms of this authorization by signing below.

	Signature Required:	Printed Name:	Date:
Applicant	X		
Applicant's Spouse	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		

If your application is dated more than 60 days before the requested effective date for coverage, a new application may need to be completed.

Note: Coverage will not begin until all necessary information is received by MHP. MHP will notify you of the approved effective date.

Applicant's Name: _____

Payment Information

All premium payments are made either via debit ACH (automatic withdrawal) [or by] Credit Card payment* [or by monthly invoice].

Please check your method of payment:

☐ Monthly Invoice – An invoice will be sent monthly to your home billing address unless a separate billing address is listed below:

_____

Name Address (street and P.O. Box if applicable) City State Zip

☐ Automatic Bank Account Withdrawal

☐ Checking account (attach voided check below) Account # _____ Routing #_____
☐ My first payment only ☐ My first and ongoing payments ☐ My ongoing payments only (first payment made by other method)

☐ Savings Account (attach deposit slip)) Account # _____ Routing #_____
☐ My first payment only ☐ My first and ongoing payments ☐ My ongoing payments only (first payment made by other method)

I authorize Mercy Health Plans (MHP) to draft my Bank Account on the [15th][day] of each month for the amount of my monthly premium. I understand that this authorization is in effect until I notify MHP in writing that I no longer desire these services, allowing them reasonable time to act upon my notification.

Signature of Account Holder: X	Date: X

☐ Credit Card Payment

Type of Credit Card: ☐ VISA ☐ MasterCard ☐ American Express

Credit Card Number:	Expiration Date: _____/_____(mm/yy)

Cardholder's Name (as it appears on the card):

Cardholder's Address: City State Zip

Telephone:

☐ *I authorize Mercy Health Plans to charge my credit card on the [15th][day] of each month for the amount of my monthly premium [plus a 2% administrative fee].*

☐ *I authorize a one-time charge to my credit card for $_____ premium [plus a 2% administration fee].*

Signature of Cardholder: X	Date: X

☐ NEW LIST BILL – Billing through a third-party (This option must have prior approval and requires separate List Bill forms to be completed and submitted with this application).

☐ CHANGE TO EXISTING LIST BILL

Note: You may be charged an additional fee for insufficient funds or incorrect banking information

Attach Voided Check Here

SECONDARY HEALTH QUESTIONNAIRE

Note: You must answer each question for yourself and for everyone you are applying for. Answer all categories 'YES' or 'NO'. If you answer 'YES' to a category, make sure to complete the detailed section not only for yourself but for everyone you are applying for.

Have you/family member ever been diagnosed with, or sought treatment for any of the following conditions?

	YES	NO
1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/ Pre-Diabetes/Hypoglycemia	☐	☐

If YES, list family member(s) affected:

_____

Diabetes/Pre-diabetes	☐	☐
Which type of diabetes has been diagnosed?		
Type I, Insulin Dependent	☐	☐
If Type I, # units of insulin per day?		
☐ < 75 units ☐ > 100 units		
☐ 75-100 units ☐ Don't know		
Type II, Non-Insulin dependent	☐	☐
Gestational	☐	☐
Date of delivery (in MM/YYYY)	____/____	
Other type/Don't know	☐	☐
Date initial diabetes diagnosis made: (MM/YYYY)	____/____	
Oral meds to control blood sugar?	☐	☐
Provide recent HbA1c or average glucose levels (within last six months).		
If fasting glucose levels		
☐ 65-115 ☐ 116-175 ☐ >175		
If random glucose levels		
☐ <200 ☐ 201-250 ☐ >250		
If HbA1c level _____		
In addition, do you/family member have any of these conditions?		
Diabetic eye complications	☐	☐
Peripheral neuropathy	☐	☐
High Blood Pressure	☐	☐
Coronary Artery Disease	☐	☐
Kidney Problems/Renal Failure	☐	☐
Hypoglycemia	☐	☐

	YES	NO
2. Endocrine System/Thyroid/Pituitary/Adrenal	☐	☐

If YES, list family member(s) affected:

_____

Hyperthyroidism/Hashimoto's Thyroiditis/Graves Disease/ Excess thyroid hormone	☐	☐
What kind of treatments have you/family member had for this?		
☐ Surgery ☐ Radioactive Iodine ☐ Other		
If surgery, date of surgery: (MM/YYYY)	____/____	
If surgery not done, does RX control disease?	☐	☐
Hypothyroidism-low thyroid hormone	☐	☐
Toxic Thyroid Goiter-Plummer's Disease	☐	☐
When was diagnosis made (in MM/YYYY)?	____/____	
Hyperparathyroidism	☐	☐
Did you/family member have surgery for?	☐	☐
If NO, does medication control disease?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Hyperaldosteronism (Cushing's disease)	☐	☐
Is the cause of disease known?	☐	☐
If cause is known, describe condition:		

_____

_____

	YES	NO
Date condition diagnosed: (in MM/YYYY)	____/____	
Is the condition stable with treatment?	☐	☐
Addison's Disease (Chronic Adrenal Insufficiency)	☐	☐
Growth Hormone Deficiency	☐	☐
Other Thyroid/Endocrine system disorder	☐	☐
Please describe:_____		

_____

_____

	YES	NO
3. High Blood Pressure/Hypertension	☐	☐

If YES, list family member(s) affected:

_____

THREE recent blood pressure readings in systolic/diastolic format

Systolic	Diastolic	Date Taken

Readings taken while on meds for hypertension?	☐	☐
Diagnosed with malignant hypertension?	☐	☐
Has the diagnosis of hypertension required:		
An ER visit?	☐	☐
A hospital stay?	☐	☐

	YES	NO
4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol	☐	☐

If YES, list family member(s) affected:

_____

Aneurysm	☐	☐
Which type of aneurysm?		
☐ Abdominal/Descending Thoracic Aortic ☐ Brain		
☐ Femoral/Peripheral ☐ Other type		
Has aneurysm been operated on?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
If NO, any further problems?	☐	☐
Hypercholesterolemia/Hyperlipidemia/High blood lipids/High blood cholesterol	☐	☐
What are cholesterol levels (in mg/dl)?		
☐ <=220 ☐ >220<=250		
☐ >250<=300 ☐ >300		
Are above levels while on cholesterol meds?	☐	☐
Anemia	☐	☐
What type of anemia do you/family member have?		
☐ Unknown/Other ☐ Thalassemia Major		
☐ Pernicious ☐ Iron Deficiency		
☐ Sickle Cell ☐ Hemolytic Anemia		
If hemolytic, have you/family member had a splenectomy?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Bleeding disorders/Hemophilia	☐	☐

	YES	NO
Coronary Artery Disease/Heart Attack/Myocardial Infarction	☐	☐
Have you/family member had?		
☐ Angioplasty/Balloon/Stent Procedure - How many? _____		
☐ Cardiac Bypass Surgery		
☐ Neither Angioplasty nor Bypass Surgery		
If performed, date procedure done: (MM/YYYY)	____/____	
If history of heart attacks, give date: (MM/YYYY)	____/____	
Congestive Heart Failure	☐	☐
Is the only treatment drug therapy?	☐	☐
Have you/family member had any hospitalizations for?	☐	☐
Cardiomegaly/Enlarged heart	☐	☐
Are you/family member a heart transplant candidate?	☐	☐
Is the reason for the enlargement known?	☐	☐
If known, describe:_____		
Do you/family member have any impairment from condition?	☐	☐
Peripheral Vascular Disease/Claudication	☐	☐
Is diagnosis?		
☐ Reynaud's Disease		
☐ Buerger's Disease		
☐ Neither Reynaud's or Buerger's		
Cerebral Vascular Accident (CVA)/Stroke/Transient Ischemic Attack (TIA)/Small Stroke	☐	☐
Was diagnosis CVA or TIA? ☐ CVA ☐ TIA		
Date symptoms began: (MM/YYYY)	____/____	
Any residual impairment?	☐	☐
Arrhythmias/Atrial Fibrillation/Rhythm Problem	☐	☐
Episodes are: ☐ Single ☐ Multiple ☐ Chronic		
If multiple, are they controlled?	☐	☐
If YES, are they controlled by?		
☐ Drugs ☐ Surgical device		
Conduction disturbances/Bundle Branch Blocks	☐	☐
Cause known for conduction disturbances?	☐	☐
If cause known, describe:_____		
Cardiac implantable device/pacemaker installed?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Chest pain/Angina/Ischemic Heart Disease	☐	☐
Is clinical work up suggestive of coronary artery disease/blocked cardiac arteries?	☐	☐
If NO, date of symptoms onset: (in MM/YYYY)	____/____	
Deep Vein Thrombosis/Blood Clots in Legs/Phlebitis	☐	☐
Do you/family member currently have one of these conditions?	☐	☐
Have you/family member had?		
☐ Single episode ☐ Multiple episodes		
If single episode, date of onset of symptoms: (MM/YYYY)	____/____	
If multiple, date recovered from last episode: (MM/YYYY)	____/____	
Are you/family member on anti-clotting RX?	☐	☐
Edema/Swelling of the extremities	☐	☐
Do you/family member know what is causing swelling?	☐	☐
If YES, describe:_____		

	YES	NO
Cardiac Valve disorders/Heart Murmur/Valve Prolapse/ Regurgitation/Stenosis of Valve	☐	☐
Have you/family member had surgery for condition?	☐	☐
If YES, was the valve: ☐ Repaired ☐ Replaced		
If YES, date of surgery: (MM/YYYY)	____/____	
If NO, are you/family member symptomatic?	☐	☐
Carotid Artery Occlusion	☐	☐
Is disease symptomatic and documented?	☐	☐
Have you/family member had surgery to correct?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Cardiomyopathy	☐	☐
Are you/family member on the waiting list for heart transplant?	☐	☐
Do you/family member know what is causing cardiomyopathy?	☐	☐
If YES, describe:_____		
Pericarditis	☐	☐
Did you/family member have surgery?	☐	☐
If surgery, date of surgery: (MM/YYYY)	____/____	
Other disease of the heart or circulatory system	☐	☐
Please describe:_____		

	YES	NO
5. Respiratory/Lung Disorder/Asthma/TB/COPD	☐	☐
If YES, list family member(s) affected:		
Allergies/Asthma	☐	☐
Do you/family member have?		
☐ Asthma & Allergies		
☐ Allergies Only ☐ Asthma Only		
If allergies, are you/family member on desensitization shots?	☐	☐
If asthma, are attacks occasional or frequent?		
☐ Occasional ☐ Frequent		
If asthma, any hospitalizations for?	☐	☐
If asthma, nebulizer used for acute episodes?	☐	☐
If asthma, are you/family member taking corticosteroids?	☐	☐
Is asthma under control with medications?	☐	☐
Chronic Obstructive Lung Disease (COPD) or Emphysema	☐	☐
Sleep Apnea	☐	☐
If YES, do you/family member have a C-Pap machine?	☐	☐
If NO, has it been recommended by a health care provider that you/family member get a C-Pap machine?	☐	☐
Have you/family member had surgery for?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Bronchitis	☐	☐
In last two years number of hospitalizations for bronchitis?		
☐ Not at all ☐ One time ☐ > Than once		
Pulmonary Embolism/Pulmonary Infarction	☐	☐
Is it known what caused embolism/infarction?	☐	☐
Please describe:_____		
Single episode of symptoms?	☐	☐
Are you/family member continuing anticoagulant drug treatment?	☐	☐

	YES	NO
Have you/family member fully recovered?	☐	☐
Dyspnea/Shortness of Breath	☐	☐
Known underlying condition causing this?	☐	☐
Please describe underlying condition:_____		
Is the shortness of breath exercise induced?	☐	☐
How would you/family member characterize symptoms? ☐ Mild ☐ Moderate ☐ Severe		
Pulmonary Hypertension	☐	☐
Are you/family member a recipient/candidate for a lung transplant?	☐	☐
Other respiratory condition	☐	☐
Please describe:_____		

6. Ear/Eye/Nose/Throat/Skin Disorder	YES ☐	NO ☐
If YES, list family member(s) affected: _____		
Middle ear infections/tubes in ears/Otitis Media	☐	☐
Are infections chronic?	☐	☐
Has there been more than one infection?	☐	☐
Are tubes present in ear canals?	☐	☐
Date of most recent episode: (MM/YYYY)	____/____	
Any hearing impairment?	☐	☐
If YES, does it require a hearing aid?	☐	☐
If YES, do you/family member need a cochlear implant?	☐	☐
Cataracts	☐	☐
Both eyes?	☐	☐
Have you/family member had surgery on?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Glaucoma	☐	☐
If YES, provide current ocular pressure: _____		
Tonsillitis	☐	☐
Have you/family member had surgery for?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Single episode of symptoms?	☐	☐
Date of last episode of symptoms: (MM/YYYY)	____/____	
Psoriasis/Chronic Skin Condition/Eczema	☐	☐
Episodes are: ☐ Mild ☐ Moderate ☐ Severe		
Taking Enbrel/Other Biologic RX injections for?	☐	☐
Acne	☐	☐
Cellulitis-skin infection	☐	☐
More than one episode?	☐	☐
Are the episodes severe?	☐	☐
When was since last episode? (MM/YYYY)	____/____	
Sinusitis/Sinus Infection	☐	☐
Is condition chronic?	☐	☐
How many infections do you/family member have a year? _____		
Other Ear/Eye/Nose/Throat or Skin condition	☐	☐
Please describe:_____		

7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/Polyps/Hepatitis/Cirrhosis	YES ☐	NO ☐
If YES, list family member(s) affected: _____		
GERD/Gastroesophageal Reflux Disease/Acid Reflux	☐	☐
Did symptoms abate/improve with drug therapy?	☐	☐
Are drugs you/family member taking prescribed by physician?	☐	☐
Ulcers/Peptic Ulcers/Duodenal Ulcers/Gastric Ulcers	☐	☐
Have you/family member had surgery for condition?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Crohn's Disease/Inflammatory Bowel Disease	☐	☐
Have you/family member had surgery for condition?	☐	☐
If YES, what kind of surgery was done? ☐ Partial bowel resection ☐ Total bowel resection		
If YES, date of surgery: (MM/YYYY)	____/____	
Colitis/Irritable Bowel Syndrome (IBS)/Spastic Colitis	☐	☐
☐ Currently under treatment ☐ Single Attack in the past ☐ Multiple Attacks in the past		
If multiple date of last episode of symptoms: (MM/YYYY)	____/____	
Gastrointestinal Bleeding	☐	☐
When was last bleeding episode? (MM/YYYY)	____/____	
Are you/family member currently under treatment?	☐	☐
Cirrhosis of the Liver/Hepatitis/Liver Disease	☐	☐
Which type of liver disease has been diagnosed? ☐ Cirrhosis ☐ Hepatitis C ☐ Hepatitis A ☐ Alcoholic Hepatitis ☐ Hepatitis B ☐ Chronic Hepatitis		
If Hepatitis A, B or C - Normal liver function tests?	☐	☐
If Hepatitis C - Taking Interferon by injection?	☐	☐
Gall Bladder Disease/Cholelithiasis/Cholecystitis	☐	☐
Was it a single attack of symptoms?	☐	☐
Has the gall bladder been removed?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
If NO, date of last attack of symptoms? (MM/YYYY)	____/____	
Fatty Liver (NASH)	☐	☐
Ulcerative Colitis/Chronic Inflammation of Colon	☐	☐
Single or multiple episodes?	☐	☐
Have you/family member had surgery for condition?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
If YES, are you/family member on prescription medications?	☐	☐
If NO, is condition under control?	☐	☐
If NO, are you/family member taking steroid medication?	☐	☐
If NO, date last episode of symptoms: (MM/YYYY)	____/____	
Diverticulitis/Diverticulosis	☐	☐
Do you/family member currently have symptoms from this?	☐	☐
Have you/family member had surgery for?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Colon Polyps/Rectal Polyps	☐	☐
Benign?	☐	☐
Have you/family member had surgery on?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Hernia	☐	☐
If YES, what kind of hernia? ☐ Inguinal ☐ Femoral ☐ Scrotal ☐ Ventral		
Has it been operated on?	☐	☐
If no, any symptoms from?	☐	☐
If no operation and symptomatic, are symptoms managed by medicine?	☐	☐
Pancreatitis	☐	☐

	YES	NO
Is condition chronic or acute?	☐	☐
Any history of alcohol use?	☐	☐
Any subsequent liver disease?	☐	☐
Single episode of pancreatitis?	☐	☐
Do you/family member currently have this condition?	☐	☐
If NO, date of last episode of symptoms: (MM/YYYY)	____/____	
Other digestive/intestinal disorder	☐	☐

Please describe: _____

_____

_____

8. Prostate/Reproductive Organ Disorder/ Infertility/ STD	YES ☐	NO ☐

If YES, list family member(s) affected:

_____

Uterine fibroids/Dysfunctional Uterine Bleeding	☐	☐
Have you/family member had a hysterectomy?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Was there a malignancy?	☐	☐
Benign Prostatic Hypertrophy/Prostatic Enlargement	☐	☐
Is there a malignancy?	☐	☐
Have you/family member had prostate surgery?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Any symptoms or voiding difficulties related to prostatic enlargement?	☐	☐
Sexually transmitted diseases	☐	☐
Which type?		
☐ Genital Herpes-Date of last episode: (MM/YYYY)	____/____	
☐ Chlamydia - Is it present at this time?	☐	☐
☐ Gonorrhea - Is it present at this time?	☐	☐
☐ Syphilis - Is it present at this time?	☐	☐
☐ Venereal Warts - Is it present at this time?	☐	☐
Infertility	☐	☐
If YES, are you/family member on infertility treatments?	☐	☐
Ovarian cysts	☐	☐
Are the cysts benign?	☐	☐
Any symptoms from condition?	☐	☐
Cervical Dysplasia/Abnormal Pap Smears	☐	☐
More than one abnormal Pap in the last 2 years?	☐	☐
Prolapsed Uterus	☐	☐
Have you/family member had surgery to correct?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Do you/family member have a history of complications of pregnancies or deliveries?	☐	☐
Have you/family member had an infant that was premature?	☐	☐
With congenital abnormalities/anomalies/defects?	☐	☐

Please describe: _____

_____

Other disorder/abnormality of the reproductive system	☐	☐

Please describe: _____

_____

9. Urinary Tract/Kidney or Renal Disease	YES ☐	NO ☐

If YES, list family member(s) affected:

_____

Cystitis/Urinary Tract Infection (UTI)/Pyuria/Urethritis	☐	☐
Single episode?	☐	☐
When was last episode (in MM/YYYY)?	____/____	
Was there any protein/discharge/blood in urine?	☐	☐
Cystic disease of kidneys	☐	☐
☐ Solitary Cyst ☐ Polycystic		
Have you/family member had surgery?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Have you had a kidney transplant	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
Any post-surgical complications?	☐	☐
Renal calculi/Kidney stones	☐	☐
Currently have?	☐	☐
If NO, date of last episode: (MM/YYYY)	____/____	
More than two episodes of symptoms?	☐	☐
Were stones in one or both kidneys?	☐	☐
☐ Unilateral/One kidney only		
☐ Bilateral/Both kidneys		
Interstitial cystitis	☐	☐
Currently have?	☐	☐
If NO, date of last episode: (MM/YYYY)	____/____	
Acute Renal failure/Chronic Renal failure	☐	☐
Currently have?	☐	☐
If NO, date of recovery: (MM/YYYY)	____/____	
Urinary Incontinence	☐	☐
Other Kidney/Urinary tract disorder	☐	☐

Please describe: _____

_____

10. Nervous System/Brain Disorder/Headache/ Epilepsy/Seizure Disorder	YES ☐	NO ☐

If YES, list family member(s) affected:

_____

Headaches/Migraines/Cluster Headaches	☐	☐
Situational Headaches (menstrual, stress, other)?	☐	☐
Characterization of severity & frequency of headaches (Pick one):		
☐ Mild and/or less than 5/year ☐ Severe and/or > 10/year		
☐ Moderate and/or 5 - 10/year ☐ Onset less than 6 months		
Head Injury/Concussion	☐	☐
Was there a loss of consciousness?	☐	☐
If YES, how long was loss of consciousness?		
☐ < 1 hour ☐ < 1 day ☐ More than 1 day		
If < 1 hour, any residual problems post recovery?	☐	☐
If < 1 day, give date of recovery: (MM/YYYY)	____/____	
If < 1 day, any residual problems post recovery?	☐	☐
Encephalitis/Encephalomyelitis	☐	☐
Currently have?	☐	☐
If NO, any residual complications post recovery?	☐	☐
If NO, how long since recovery (in MM/YYYY)?	____/____	
Neuroma/Abnormal Nerve Growth	☐	☐
Is growth benign?	☐	☐
Have you/family member been operated on?	☐	☐
If YES, when was surgery (MM/YYYY)?	____/____	
If NO, when was recovery (MM/YYYY)?	____/____	
Is the diagnosis Morton's Neuroma?	☐	☐
Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's Disease	☐	☐
Reflex Sympathetic Dystrophy	☐	☐
If YES, have currently or recovered from?		
☐ Current ☐ Recovered from		

YES NO

If recovered, date of recovery: (MM/YYYY) ____/____
Chronic Fatigue Syndrome ☐ ☐
If YES, have currently or recovered from?
☐ Currently have ☐ Recovered from
If recovered, date of recovery: (MM/YYYY) ____/____
Peripheral Neuropathy ☐ ☐
Is another disease condition causing neuropathy? ☐ ☐
If YES, please describe:_____
_____
Epilepsy/Seizure Disorder ☐ ☐
Do you/family member know what type of seizure has been diagnosed? ☐ ☐
If YES, what is seizure type?
☐ Febrile ☐ Petit Mal ☐ Jacksonian
☐ Grand Mal ☐ Focal
Is another disease condition causing seizures? ☐ ☐
If YES, please describe:_____
_____
Heat Exhaustion/Heat Stroke ☐ ☐
Which diagnosis? ☐ Heat Exhaustion ☐ Heat Stroke
Single episode? ☐ ☐
If NO, date of last episode: (MM/YYYY) ____/____
Autism ☐ ☐
Cerebral Palsy ☐ ☐
Paralysis/Hemiplegia/Paraplegia ☐ ☐
Parkinson's Disease ☐ ☐
Spina Bifida ☐ ☐
Viral Meningitis ☐ ☐
Bacterial Meningitis ☐ ☐
Muscular Dystrophy ☐ ☐
Multiple Sclerosis ☐ ☐
Motor Neuron Disease ☐ ☐
Neuralgia/Neuritis ☐ ☐
Dementia ☐ ☐
Other disorder of the nervous system ☐ ☐
Please describe:_____
_____

YES NO

11. Mental or Psychiatric Condition/Depression/ Behavioral (e.g., Attention-Deficit Hyperactivity Disorder) or Eating Disorder ☐ ☐

If YES, list family member(s) affected:
_____
Affective Disorders ☐ ☐
What is diagnosis (pick one below)?
☐ Obsessive Compulsive Disorder (OCD)
☐ Panic Disorder ☐ Agoraphobia
☐ Anxiety Disorder ☐ Neuroses
Is treatment effective? ☐ ☐
If YES, date treatment became effective? (MM/YYYY) ____/____
What is characterization of severity of symptoms?
☐ Mild ☐ Moderate ☐ Severe
Schizophrenia/Paranoia ☐ ☐
Eating Disorder/Bulimia/Anorexia ☐ ☐
Do you/family member currently have an eating disorder? ☐ ☐
When was recovery? (MM/YYYY) ____/____
Attention Deficit Disorder/ADD/ADHD ☐ ☐

YES NO

What is characterization of severity of symptoms?
☐ Mild ☐ Moderate ☐ Severe
Are symptoms controlled by medication? ☐ ☐
Situational Depression/Mild Depression/Anxiety ☐ ☐
Is only current treatment prescription medication? ☐ ☐
Major Depression/Bipolar Disorder ☐ ☐
When was diagnosis made? (MM/YYYY) ____/____
Have you/family member ever sought, or are you seeking professional counseling/therapy for a mental health issue? ☐ ☐
Date of last treatment? (MM/YYYY) ____/____
Other mental health/psychiatric disorder ☐ ☐
Please describe:_____
_____
_____

YES NO

12. Back or Neck Disorder/Lumbago/Disc Herniation or Protrusion/Sciatica/Sacroiliac Disorder ☐ ☐

If YES, list family member(s) affected:
_____
Cervical (Neck) or Thoracic (Mid Back) or Lumbar (Low Back) Disc Herniation or Protrusion ☐ ☐
Are you/family member under current treatment for? ☐ ☐
Have you/family member had surgery for condition? ☐ ☐
If YES, any subsequent problems post-op? ☐ ☐
If YES, date of surgery: (MM/YYYY) ____/____
If no surgery was done, have you/family member recovered? ☐ ☐
If you/family member have recovered, date of Recovery: (MM/YYYY) ____/____
Low Back Pain/Lumbago/SI Joint/Sciatica ☐ ☐
Are you/family member under current treatment for? ☐ ☐
If not in current treatment, date of last episode: (MM/YYYY) ____/____
Spinal Fractures ☐ ☐
Any lingering neurological defects? ☐ ☐
Was fracture a compression fracture? ☐ ☐
When was last treatment (in MM/YYYY)? ____/____
Spinal Stenosis ☐ ☐
Have you/family member had surgery for condition? ☐ ☐
If YES, date of surgery: (MM/YYYY) ____/____
Low Back Strain/Whiplash/Muscle Spasm ☐ ☐
Are you/family member under current treatment for? ☐ ☐
Ankylosing Spondylitis/Spondylolisthesis ☐ ☐
Have you/family member had surgery for condition? ☐ ☐
If YES, date of surgery: (MM/YYYY) ____/____
f NO, is condition symptomatic/requiring treatment? ☐ ☐
Sciatica/Radiculitis/Radiating pain to legs or arms ☐ ☐
Do you/family member have any neurological defects? ☐ ☐
Are you/family member currently under treatment for? ☐ ☐
Are episodes recurrent? ☐ ☐
When was last episode (in MM/YYYY)? ____/____
Spinal deformities/Scoliosis/Lordosis ☐ ☐
Have you/family member had surgery for condition? ☐ ☐
If surgery, any continuing problems post-op? ☐ ☐
If surgery was done, date of surgery: (MM/YYYY) ____/____
If no surgery, are you/family member currently under treatment? ☐ ☐

YES NO

If you/family member are currently under treatment, is condition?
☐ Mild ☐ Moderate ☐ Severe
If no current treatment, date of last treatment?
(MM/YYYY) ____/____
Spina Bifida/Myelocele ☐ ☐
Have you/family member had surgery for condition? ☐ ☐
If YES, date of surgery: (MM/YYYY) ____/____
If YES, any residual neurological defects? ☐ ☐
Other back/neck disorder ☐ ☐
Please describe:_____

13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disease/TMJ ☐ ☐

If YES, list family member(s) affected:

Arthritis ☐ ☐
Kinds of arthritis do you/family member have?
☐ Degenerative ☐ Chronic proliferative
☐ Hypertrophic ☐ Arthritis deformans
☐ Senile ☐ Psoriatic
☐ Juvenile Rheumatoid ☐ Chondrocalcinosis
☐ Adult Rheumatoid ☐ Septic
☐ Atrophic ☐ Acute Infectious
☐ Osteoarthritis
Is condition asymptomatic? ☐ ☐
If symptomatic, date of first onset of symptoms:
(MM/YYYY) ____/____
Is more than one joint affected? ☐ ☐
If no, is the joint a hip or knee? ☐ ☐
Have you/family member had a hip/knee replacement? ☐ ☐
If you/family member had surgery, date of surgery:
MM/YYYY) ____/____
Characterization of disease progression/degree of disability:
☐ Mild, Minimal ☐ Moderate to Severe
Is there a joint infection? ☐ ☐
Osteomyelitis/Bone Infection/Bone Abscess ☐ ☐
Was there only a single episode? ☐ ☐
Involved joint/bone was:
☐ Major joint/bone ☐ Minor joint/bone
TMJ Disorder/Disease ☐ ☐
TMJ Syndrome/Jaw Pain ☐ ☐
Under current treatment for? ☐ ☐
If NO, date treatment completed: (MM/YYYY) ____/____
Bursitis/Tennis Elbow/Tendonitis/Synovitis ☐ ☐
Was there only a single episode of symptoms? ☐ ☐
Under current treatment for? ☐ ☐
Osteoporosis ☐ ☐
Is underlying cause known for condition? ☐ ☐
If YES, please describe cause for condition below:
_____
Any symptoms from? ☐ ☐
Any subsequent fractures? ☐ ☐
Do you/family member take steroids for condition? ☐ ☐
Carpal Tunnel Syndrome ☐ ☐
Have you/family member had surgery for? ☐ ☐
If YES, date of surgery: (MM/YYYY) ____/____
Ligament tears/Torn Meniscus/Osteochondritis/
Dessicans/Chondromalacia ☐ ☐
Have you/family member had surgery for? ☐ ☐
If surgery, date of surgery: (MM/YYYY) ____/____
Bone dislocation ☐ ☐
Was the dislocation (choose one, below)?
☐ Congenital hip ☐ Patella (kneecap)
☐ Shoulder ☐ Knee (not kneecap)
☐ Hip-traumatic ☐ Other joint-traumatic
Was there a single episode of symptoms? ☐ ☐
Do you/family member currently have? ☐ ☐
Have you/family member had surgery on? ☐ ☐
If YES, date of surgery: (MM/YYYY) ____/____
Dislocation was:
☐ Unilateral/one sided ☐ Bilateral/both sides
Bone fracture ☐ ☐
Has treatment been completed? ☐ ☐
Have you/family member had surgery on? ☐ ☐
If YES, date of surgery: (MM/YYYY) ____/____
Was the fracture? ☐ Union ☐ Non-Union
Was the fracture of?
☐ Leg/hip/foot
☐ Arm/hand/shoulder
☐ Other bone
Foot pain ☐ ☐
Bunions ☐ ☐
If YES, have you/family member had surgery for? ☐ ☐
If YES, date of surgery: (MM/YYYY) ____/____
Plantar fasciitis ☐ ☐
Rotator cuff tear ☐ ☐
Have you/family member had surgery on? ☐ ☐
If YES, date of surgery: (MM/YYYY) ____/____
Date of original injury: (MM/YYYY) ____/____
Gout/Gouty Arthritis/Hyperuricemia ☐ ☐
Characterization of number of attacks:
☐ Few ☐ Frequent
Are attacks well controlled by medication/diet? ☐ ☐
Other bone/joint disorder ☐ ☐
Please describe:_____

14. Muscular Disorder/Lupus/Connective Tissue/ Autoimmune Disorder ☐ ☐

If YES, list family member(s) affected:

Collagen diseases:Scleroderma/Ehlers-Danlos Syndrome/Mixed Connective Tissue disease/
Necrotizing Angiitis ☐ ☐
Lupus Erythematosus ☐ ☐
Fibromyalgia/Myitis/Myositis ☐ ☐
Currently being treated? ☐ ☐
If no current treatment, date of recovery:
(MM/YYYY) ____/____
Recurrent episodes? ☐ ☐
Polymyositis/Neuromyositis/Dermatomyositis ☐ ☐
Autoimmune Disorder/Disease ☐ ☐
Please describe:_____

Ligament tears/Meniscus tears/Osteochondritis/
Dessicans/Chondromalacia ☐ ☐

	YES	NO
Have you/family member had surgery for condition?	☐	☐
If surgery, date of surgery: (MM/YYYY)	____/____	
Other Muscle/Connective Tissue/Autoimmune disorder	☐	☐

Please describe:_____

_____

15. Cancer/Tumors/Cysts/Neoplasm	YES ☐	NO ☐

If YES, list family member(s) affected:

_____

Cancer	☐	☐
Breast Cancer	☐	☐
Thyroid Cancer	☐	☐
Basal Cell/Squamous Cell Skin Cancer	☐	☐
Prostate Cancer	☐	☐
Lipoma/Adipose Tumor	☐	☐
Colon/Rectal Cancer	☐	☐
Melanoma	☐	☐
Other kind of cancer	☐	☐

Please describe:_____

_____

Are you/family member under current treatment?	☐	☐
If NO, date treatment completed: (MM/YYYY)	____/____	
What was stage of the tumor?		
☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV		
When diagnosed? (in MM/YYYY)	____/____	
Was the treatment surgery alone?	☐	☐
If YES, date of surgery: (MM/YYYY)	____/____	
If not, what were the other treatments?	☐	☐

Please describe:_____

_____

Is cancer in remission?	☐	☐
Is the cancer metastatic?	☐	☐
Is the cancer recurrent?	☐	☐
Have you/family member been told you have an abnormal, suspicious lesion/possible pre-malignant condition?	☐	☐
Has the lesion been removed?	☐	☐
Cyst	☐	☐

Please describe:_____

Has the cyst been removed?	☐	☐

16. HIV/AIDS/ARC Chronic or Infectious Disease	YES ☐	NO ☐

If YES, list family member(s) affected:

_____

HIV (human immunovirus)	☐	☐
AIDS (Acquired Immune Deficiency Syndrome)	☐	☐
ARC (AIDS related complex)	☐	☐
Other chronic or Infectious disease	☐	☐

Please describe:_____

_____

_____

17. Any other Illness, Disease, Condition or Injury	YES ☐	NO ☐

If YES, list family member(s) affected:

_____

As a result of an injury or illness have you/family member had any of the treatments listed below?	☐	☐
Bone or skin graft(s)	☐	☐
Joint replacement	☐	☐
Loss of limb	☐	☐
Loss or surgical removal of organ	☐	☐

If YES, please describe:_____

_____

_____

_____

_____

_____

_____

Other Disease/Disease Condition/Disorder/Injury not previously described	☐	☐

Please describe:_____

_____

_____

_____

_____

_____

Date of last treatment (in MM/YYYY): ____/____

Treating Physician:_____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by Mercy Health Plans. Your new policy provides ten (10) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have and pre-existing conditions may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to:

Mercy Health Plans
521 President Clinton Avenue • Suite 700
Little Rock, AR 72201

Within ten (10) days, if any information is not correct and complete, or if any past medical history has been left out of the application.

The above "Notice to Applicant" was delivered to me on:

_____ _____ / ____ /
Applicant's Signature Date

HEARING AID SERVICES RIDER

This Rider amends the Individual Comprehensive Health Insurance Policy and the Schedule of Coverage and Benefits attached thereto (collectively the "Policy") and, unless expressly stated in this Rider, is subject to all the provisions, exclusions and limitations set forth in the Policy. All capitalized terms shall have the meanings given them in the Policy.

Except as modified or superceded by the coverage provided under this Rider, all other terms, conditions, exclusions in the Policy remain unchanged and in full force and effect.

Covered Services:

Members are entitled to coverage for up to one (1) non-digital (analog), programmable hearing aid per ear every [three (3) [Rolling] [Plan] [Calendar] Years] [thirty-six (36) consecutive months]. Members may apply the "standard benefit" towards the purchase of additional functionality (i.e., digital). Coverage is provided for behind-the-ear (BTE) or in-the-ear (ITE) hearing aids and includes associated hearing aid fitting/dispensing fees. Members are responsible for any additional charges for functionality enhancements and/or components.

Members shall be entitled to a total maximum Benefit of $1,400 per ear net expense applicable toward the purchase, repair of hearing aids and replacement parts every [three (3) [Rolling][Calendar][Plan] Years][thirty-six (36) consecutive months].

Coverage of hearing aids is not subject to any Deductible, Coinsurance or Copayment.

[Hearing Testing: Specialist Copayment for annual hearing test will apply. If hearing test is done in conjunction with an office visit, only one Copayment applies]

Note: [The Deductible and Coinsurance described in this Rider shall not be counted against the applicable Out-of-Pocket Maximum as set forth in the Schedule of Coverage and Benefits.] [Only] [Deductibles,] [and] [Coinsurances][and Copayments] for Covered Services described in this Rider will count towards your Out-of-Pocket Maximum.]

Exclusions:

Under no circumstances will coverage be provided for:

1. Charges for hearing aid batteries, listening devices and/or repairs, and any additional charges for functionality enhancements and/or components.
2. Hearing aids when the device cannot assist the hearing loss.
3. BAHA or osseointegrated hearing aids.

[Prior Authorization Required
Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by [50%-100%] of Eligible Expenses.]

Charles S. Gilham, Vice-President
Mercy Health Plans

HEARING AID SERVICES RIDER

ELECTION FORM

Upon renewal, the Individual policyholder may accept or reject coverage required to be offered under this Rider.

Please check one: ☐ I elect coverage for Hearing Aid Services at an additional cost of $ _____ /month/per applicant.

☐ I do not elect coverage for Hearing Aid Services.

If elected, this Rider will remain in effect as long as the Certificate of Coverage remains in effect, except this Rider may be terminated on the anniversary of this Policy upon at least thirty (30)-days prior written notice to Mercy Health Plans.

_____ _____/_____/_____

Policyholder's Signature Date

_____ _____/_____/_____

Mercy Health Plans Account Executive Date

SERFF Tracking Number:	*MHPL-126293991*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*43425*
Company Tracking Number:	*INDIVAPP2010*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*INDIVAPP2010*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/09/2009

Comments:
AR Certification attached.
Attachment:
AR Certification.PDF

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/09/2009
Bypass Reason:	Application is the document being filed.		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/09/2009
Bypass Reason:	N/A. No rate change since last rate filing.		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/09/2009
Bypass Reason:	N/A		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Redlined Copy	Approved-Closed	09/09/2009

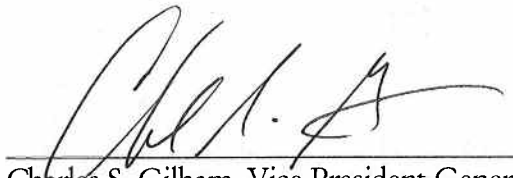
Comments:
Attachment:

SERFF Tracking Number:	*MHPL-126293991*	*State:*	*Arkansas*
Filing Company:	*Mercy Health Plans*	*State Tracking Number:*	*43425*
Company Tracking Number:	*INDIVAPP2010*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*INDIVAPP2010*		
Project Name/Number:	*/*		

AR Individual Application 2010 Redlined.pdf

CERTIFICATION

I, Charles S. Gilham, am a duly authorized officer of Mercy Health Plans and do hereby certify that, per Rule and Regulation 19 and 42, Section 5 (b), there will be no unfair discrimination with respect to the medical/lifestyle application questions and underwriting standards.



9-3-09

Charles S. Gilham, Vice President General Counsel
Mercy Health Plans
14528 S. Outer 40, Suite 300
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 214-8294

Date

Mercy*One* Application Checklist

Please follow ~~the below~~ this checklist to ensure your application is complete and ~~to~~ avoid unnecessary underwriting delays.

- ❑ Complete the General Member Information section (page *). Include the name, gender, height, weight, social security number, and date of birth for every person applying for coverage.

- ❑ ~~You may r~~Request an effective date on (page *).. You may select either ~~of~~ the [1st] or [1st and/or 15th] of the month. ~~(page *).~~

- ❑ Obtain and send to Mercy Health Plans a copy of any Certificate of Creditable Coverage, if you have had prior health insurance coverage through another carrier. We will need a copy of this Certificate in order to grant you a waiver for any pre-existing conditions.

- ❑ Select the plan option for which you will be applying (page *).

- ❑ Answer all Health History questions (page * and *). Also, list all prescriptions and over-the-counter medications taken for each person applying for coverage. Failure to answer these questions will delay the underwriting of your application.

- ❑ ~~If you answered "yes" to questions on page *, please give~~Give us complete details in the attached *Secondary ~~Questions~~Health Questionnaire* ~~section~~, if you answered "yes" to any Health History conditions listed on page * (question # 6). ~~Refer to t~~The page number(s) listed next to the condition(s) ~~on~~in this section refer to corresponding questions ~~answer~~in the Secondary Health Questionnaire.

- ❑ List the primary care physician, phone number, and date of last visit for each person applying for coverage (page*).

- ❑ Initial and date the Statements of Understanding (page *)~~:~~. ~~The primary Applicant and Spouse must initial and date this page~~.

- ❑ Sign and date the Authorization to Use and Disclose Protected Health Information (page *)~~:~~. This applies to ~~E~~each enrolling Applicant age 18 or over ~~will need to sign and date this page~~. If your application is dated more than 60 days ~~from~~ before the requested effective date, you will be asked to re-apply.

- ❑ Complete the ~~selected method of payment~~ Payment Information (page *). Payment for this policy can be made by automatic withdrawal from a checking or savings account. Mercy Health Plans ~~may also draft from a~~ also accepts Visa or MasterCard or American Express credit card payments [(plus a 2% administration fee)]. All payment options are withdrawn on a monthly basis on or about the [15th] [day] of the month.

- ❑ ~~Secondary Questions (pages * -*): Provide details for all conditions for each person applying for coverage. The primary Applicant and Spouse must initial and date each page of the Secondary Questions ensuring that all medical information is disclosed.~~

If you need assistance in completing your application, please contact your agent. If you do not have an agent, please contact the Mercy*One* Sales Department (501) 372-0065 or (~~866~~800) ~~450~~330-~~3249~~8293, or email: *mercyonearkansas@mercy.net*.

Mercy Health Plans
521 President Clinton Avenue • Suite 700
Little Rock, AR 72201
[(501) 372-0065] [~~866-647-1551~~800-330-8293]
www.mercyhealthplans.com

Individual Application for Comprehensive Health Insurance

Please complete in black only.

Application Type

Coverage Information (Select One): ☐ New Coverage _____ Effective Date Requested: ___/___/___

☐ Change to current plan_ Member Number: _____ Effective Date of Change: ___/___/___

☐ Add dependent (s) to current coverage Member Number: _____ Effective Date of Change: ___/___/___

Applicant Information

Please enter the following applicant information: (If applying for *Child Only* Coverage, record the child's information in the following section. Please submit a separate application for each Child Only Applicant.)

NAME: First Middle Last | Subscriber's Occupation:

HOME ADDRESS: (Street & P.O. Box if applicable) City State Zip County

Home Phone: (_____) _____ Best time to call: ☐ Day ☐ Evening | E-mail (this will not be shared with a 3rd party): _____

Work Phone: (_____) _____ Cell Phone #: (_____)_____

Are you a United States citizen? ☐ Yes ☐ No

If "No", do you possess a Green Card (Permanent Resident Card) or a temporary U.S. visa? ☐ Yes ☐ No If "No", please explain: _____

Are you a legal resident of the state of Arkansas? ☐ Yes ☐ No If "No", please explain: _____

Have you resided in the United States for the past six (6) consecutive months? ☐ Yes ☐ No

General Member Information

Please complete information below for all family members applying for coverage (attach other pages, if needed).

Name First	MI	Last	Relationship to Applicant	Sex M/F	Height Ft.	In.	Weight lbs.	SSN#	Date of Birth (mm/dd/yyyy)
			Self						
			Spouse						
			Child						
			Child						
			Child						
			Child						
			Child						

Will the Mercy Health Plans' coverage that you are applying for replace or change your current hospital, medical or major medical insurance? ☐ Yes ☐ No

Will any applicants be continuing any other health insurance? ☐ Yes ☐ No If 'Yes', list name(s) : _____

Producer Information

If you have a Producer (Broker or Agent) that will be assigned to your account, HAVE HIM/HER COMPLETE THIS SECTION.
Note: Mercy Health Plans (MHP) may share medical information with the Producer concerning you or your covered dependents that is contained in this application or discovered in the course of processing the application. The writing (and any assisting) Producer's current Arkansas health insurance license must be on file with MHP prior to acceptance of this application.

Do you know of any significant medical information relating to the applicant or any of his dependents that has not been reported on this form?
Yes ☐ No ☐

For purposes of processing commission, please provide the following information*:

Agency Name: _____ Broker's Name: _____

Broker's Telephone # : _____ Broker's Email: _____

Broker's Signature: _____ Date: _____

Notification: Broker Only ☐ (Broker to receive policy)
Broker and Subscriber ☐ (Member to receive policy, Broker to receive copy by email)

* Please fill out this information as it appears on your W-9 form.

Coverage and Benefit Selection

To choose the type of coverage that you would like, select ONE option from EACH of the sections numbered 1, 2, 3 and 4 below.

1) TYPE OF COVERAGE: ☐ Applicant only (Ages 19-65 yrs.) ☐ Child Only (Age 6 mos -18 yrs) ☐ Applicant & spouse
☐ Applicant & unmarried children* ☐ Applicant, spouse & unmarried children*

**Unmarried children under age 19, or who are full time students (FTS) through the date on which they turn 23 may be added to the plan. FTS documentation must accompany application. Call us for details on FTS documentation at [(501) 372-0065] [or] [~~866-450-3249~~800-330-8293].*

2) EFFECTIVE DATE REQUESTED: ____/____/____ [1st of the month only] [1st and 15th of the month only]

Note: The actual effective date will be determined by Mercy Health Plans, and if approved, you will be notified of the effective date for your policy.

3) OPTIONAL RIDERS:

Family Services Rider [(tubal ligations & vasectomies)] – Additional $____ /month (per family) (Applies only to Applicant and enrolled spouse) ☐ Yes ☐ No

Temporomandibular Joint Disorder (TMJ) Rider – Additional $ ____ /month/per applicant ☐ Yes ☐ No

Hearing Aid Services Rider – Additional $ ____ /month/per applicant ☐ Yes ☐ No

4) PLAN SELECTION: Traditional Plan Option – Choose ONLY ONE

Note: Maternity benefits apply only to the applicant or applicant's spouse, and will not begin after you have been covered for 12 months.
You must be over 19 years of age to elect maternity benefits.

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit PCP/Specialist	Coinsurance In-network/Out-of-Network	Prescription Copays
☐ ARK-A	12 month	No	$1,000	$2,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-B	12 month	No	$2,500	$5,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-C	12 month	No	$5,000	$10,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-AA	12 month	Yes	$1,000	$2,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-BB	12 month	Yes	$2,500	$5,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-CC	12 month	Yes	$5,000	$10,000	$15/$35	100/75%	$10/$40/$65/$100
☐ ARK-D	12 month	No	$500	$1,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-E	12 month	No	$1,000	$2,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-F	12 month	No	$2,500	$5,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-G	12 month	No	$5,000	$10,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-DD	12 month	Yes	$500	$1,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-EE	12 month	Yes	$1,000	$2,000	$15/$35	80/60%	$10/$40/$65/$100

☐ ARK-FF	12 month	Yes	$2,500	$5,000	$15/$35	80/60%	$10/$40/$65/$100
☐ ARK-GG	12 month	Yes	$5,000	$10,000	$15/$35	80/60%	$10/$40/$65/$100

Other Health Coverage Answer "Yes" or "No" and list and/or submit additional information as requested below.	Yes	No
1) Are you or anyone that is applying for coverage currently eligible for Medicare? If "yes", please list name(s):_____ Note: Anyone who is eligible for Medicare is not eligible for coverage under this Policy.	☐	☐
2) Have you ever had your coverage through Mercy Health Plans terminated for failure to pay premiums? If "yes", please list name(s):_____ If your coverage was terminated by Mercy Health Plans for non-payment of premiums, you must wait 12 months before applying for coverage and one month's advance premium may be required.	☐	☐
3) Did you and/or your spouse and/or your eligible dependents have creditable coverage from a health insurance carrier within the past 63 days ~~or more~~? (C~~c~~reditable C~~c~~overage is any health insurance except a short term policy) If "yes", you may be eligible for pre-existing credit. If applicable, submit a copy of the Certificate of Creditable Coverage for each person applying. ~~and complete the questions below:~~	☐	☐

Lifestyle Answer "Yes" or "No" to the questions below.	Yes	No
1) Have you or any family member(s) who are applying for coverage smoked tobacco within the last 12 months? If "yes", please list name(s):_____ Note: Additional testing may be required to confirm this information.	☐	☐
2) Have you or any family member(s) who are applying for coverage used other smokeless tobacco products within the last 12 months? If "yes", list name(s):_____ Note: Additional testing may be required to confirm this information.	☐	☐
3) Do you use alcohol or illicit drugs? If 'Yes', which do you drink/use? ☐ Alcohol ☐ Illicit drugs ☐ Both alcohol and drugs If 'Yes', how often do you drink/use? ☐ Seldom ☐ Occasionally ☐ Daily	☐	☐
4) Have you used alcohol or illicit drugs in the past? If 'Yes', when did you stop using them? ____/_____(mm/yyyy)	☐	☐

Health History~~:~~ ~~Complete your health history by a~~Answer~~ing~~ "Yes" or "No" to the questions ~~in the following section~~below.	Yes	No
~~1)Have you or any family member(s) who are applying for coverage smoked or used other smokeless tobacco products within the last 12 months? If "yes", list name(s): _____ Note: additional testing may be required to confirm this information.~~	~~☐~~	~~☐~~
1) Is any proposed insured currently pregnant, an expectant parent, or in the process of adoption or surrogate pregnancy? Note: You are not eligible for coverage if you are a male or female expectant parent	☐	☐
~~3)~~2) Do you or any family member(s) who are applying for coverage have any pain, complaints or health conditions that a reasonably prudent person would anticipate requiring future medical treatment or surgery ~~within the next 12 months~~? If so, what are those health conditions, and what treatments are considered? (Attach other pages if needed) _____ _____ _____	☐	☐

	Yes	No
~~4)~~3) In the last ten years have you or any family member(s) who are applying for coverage had any pain, complaints, symptoms, diagnoses or treatments of any disease, disorder or injury, or had any test results that you were told were abnormal or needed further evaluation? If so, what are those conditions, disease states, injuries or abnormal test results? (Attach other pages if needed) _____ _____ _____	☐	☐
~~5)~~4) Are you or any family member(s) applying for coverage taking or have taken any drugs ~~prescribed by a physician or any~~ (including over-~~-~~the-~~-~~counter drugs) or products during the past five (5) years?	☐	☐

If 'Yes', please ~~L~~list below:

- All prescription medication or over-the-counter drugs or products that are taken;
- All medication that you have been advised to take but have not;
- The person for whom each drug is prescribed;
- The prescribing physician, and
- The conditions that the drugs are prescribed to treat (attach other pages, if needed). It is important to note that if you are taking any prescribed medication, you should answer "Yes" to one or more of the questions relating to organ systems/diseases in question # (6) ~~seven (7)~~ below.

Name of Drug	Dosage Amt (e.g. 100 mg/daily)	Refill Frequency	Person Drug Prescribed For	Prescribing Physician	Condition Drug Prescribed to Treat

~~6)~~5) List Primary Care Physician, phone number and date of last visit for each person applying:

Name of Applicant:	Primary physician name, ~~and~~ phone number, city & state:	Date of last visit:

	Yes	No
6) ~~Have~~ Do you or any family member(s) applying for coverage currently have~~,~~ or have ever been diagnosed or treated for any health conditions or diseases (either Inpatient, Outpatient or Emergency Room) pertaining to the following organ systems or diseases?	☐	☐

Check "Yes" or "No" for all conditions listed below as they apply for any covered family member.

NOTE: If you answer "Yes" to any of these screening questions, you must also answer the *Secondary Questions to the Application for Individual Health Insurance* related to those conditions ~~attached to this form~~. ~~Refer to T~~the page numbers listed below refer to related questions in the attached *Secondary Questions to the Application for Individual Health Insurance*.

Yes	No		Yes	No	
☐	☐	1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes, [pg *]	☐	☐	10. Nervous System/Brain Disorder/Headache/Epilepsy/Seizure Disorder, [pg*]~~11. Epilepsy/Seizure Disorder, [pg*]~~
☐	☐	2. Endocrine/Thyroid/Pituitary/Adrenal, [pg *]	☐	☐	11. Mental or Psychiatric Condition/Depression/Behavioral- (e.g., Attention-Deficit Hyperactivity Disorder)or Eating Disorder, [pg *]~~12. Mental or Psychiatric Condition/Depression/Behavioral or Eating Disorder, [pg *]~~
☐	☐	3. High Blood Pressure/Hypertension, [pg *]	☐	☐	12. Back or Neck Disorder/Disc Herniation or Protrusion, [pg *]~~13. Drug or Alcohol Abuse, [pg *]~~
☐	☐	4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol, [pgs *]	☐	☐	13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disorder, [pgs *]~~14. Back or Neck Disorder, [pg *]~~
☐	☐	5. Respiratory/Lung/Asthma/Allergies/TB/COPD, [pg *]	☐	☐	14. Muscular Disorder/Lupus/Connective Tissue Disorder/Auto-Immune Disorder, [pg *]~~15. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder, [pgs *]~~
☐	☐	6. Ears/Eyes/Nose/Throat/Skin Disorder, [pg *]	☐	☐	15. Cancers/Tumors/Cysts/Neoplasms, [pgs *]~~16. Muscular Disorder/Lupus, [pg *]~~
☐	☐	7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/~~,~~ Polyps/~~,~~ Hepatitis/Cirrhosis [pgs *]	☐	☐	16. HIV/AIDS/ARC/Chronic or Infectious Disease, [pg *]~~17. Cancers/Tumors/Cysts, [pgs *]~~
☐	☐	8. Prostate/Reproductive Organ Disorder/Infertility/STD, [pg *]	☐	☐	17. Any Other Illness, Disease or Injury, or TMJ [pg *]~~18. HIV/AIDS/ARC/Auto-Immune Disorder, [pg *]~~
☐	☐	9. Urinary Tract/Kidney or Renal Disease, [pg *]	☐	☐	~~19. Any Other Illness, Disease or Injury, [pg *]~~
~~☐~~	~~☐~~	~~10. Nervous System/Brain Disorder/Headache, [pg*]~~			

Statements of Understanding

Please read all statements below, initial and date the bottom of this page.

1. I understand that this is an application only, and I should not cancel any coverage that I currently have until I am notified of acceptance for coverage by Mercy Health Plans (MHP).

2. I understand that I will receive either an acceptance, premium adjustment or denial from MHP or a letter explaining the reason for the delay, within 60 days of MHP's receipt of this application. Note that If accepted, [you will be required to sign and return the letter of acceptance that we will send to you][you will automatically be enrolled and your Policy will be mailed to you in the timeframe stated above].

3. I understand that if the bank returns any payments due to insufficient funds, I will be assessed a fee. Additionally, I understand that if my premiums are not paid within the billing grace period, my coverage will be terminated as to the date when my premiums were paid in full. If my coverage is terminated, I will be unable to reapply for an Individual policy with Mercy Health Plans for one year.

4. I understand that if a Producer (Agent or Broker) is handling my request, the agent is not authorized to waive a complete answer to any question, make a decision as to insurability, make or alter any contract or waive any other rights or requirements of Mercy Health Plans.

5. I understand that if I or any covered family members am/are accepted for medical coverage, any pre-existing medical and/or mental health condition disclosed within this application will not be covered for up to 12 months after my effective date. (Credit may be given for prior creditable coverage upon receipt of certificate of creditable coverage.)

6. I understand that if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits will be withheld for 12 months for that condition or the coverage may be rescinded in its entirety at MHP's discretion.

7. I understand that I or any of my covered family members may need to obtain a physical examination at my own expense and submit the results as part of my application for coverage, if such an examination has not been performed within the last two years.

8. I understand that I or any of my covered family members, must have an obligation to notify Mercy Health Plans if we become aware of any medical conditions/injuries/disease states that would cause a reasonably prudent person to seek or seek require and receive medical attention, from the time this application is completed signed to before the effective date of coverage. In this situation, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change.

9. I understand that if I purchase maternity benefits, they apply only to my spouse or me and do not begin until we have been covered for 12 months under the plan that includes the maternity benefit. Maternity benefits are not available for our dependent children and do not apply to child only plans.

10. I understand and agree that Mercy Health Plans may obtain or request information needed to process this application from me, my physician(s) and medical or pharmaceutical databases. A Mercy Health Plans' employee will then review this information. Any and all additions or corrections will then become part of the application. I understand that Mercy Health Plans will rely on this form and any information received to issue coverage.

11. I understand that if I omit or falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation of this coverage based on the terms of the policy. I agree to promptly repay any benefit payment(s) to which my covered family member(s) and/or I were not entitled.

12. I understand and agree that other health insurance coverage that I have might reduce my benefits under this Policy.

Please note:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Primary Applicant's initials: _____ Spouse's initials: _____ Date: _____

Authorization to Use and Disclose Protected Health Information

NOTE: It is required that this *Authorization to Use and Disclose Protected Health Information* be completed and submitted with the application. The application is not complete without this authorization form.

Each person age 18 or over who is to be covered by this policy must sign at the bottom of this form.

I authorize Mercy Health Plans (MHP) or its affiliates to obtain necessary individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports from physicians, hospitals or other health care providers pertaining to my care or the care of any other dependent(s) listed on the application for insurance. I understand that this information can be used to determine my/our eligibility for insurance, and that those records can be requested as far back as the past ten years.

I authorize MHP to share necessary information with my Producer (Broker or Agent). I understand that Mercy Health Plans may disclose individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports to other entities in the course of its business operations or as required or permitted by law or as set out in the Mercy Health Plans Notice of Privacy Practices and authorize such disclosure. ~~I also understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality~~ Federal regulations require that we inform you that under certain limited circumstances (e.g., judicial subpoena, state health department, etc.) the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by such regulation.

This authorization is valid for the duration of my coverage with Mercy Health Plans. I understand that this authorization is voluntary and that I may revoke this authorization at any time; however, if I do so before I am enrolled in the policy(ies), my application for coverage may be denied. A revocation request must be sent to MHP in writing to our home address, or via e-mail. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

~~All listed applicants 18 years of age and older must agree to the terms of this authorization. Signing this document confirms agreement. I understand and agree to the release of information for the purpose described above in this document.~~

By signing, I agree that I have fully read this entire application, including all seven pages of the Secondary Health Questionnaire, and I understand and agree with all statements contained herein. I also certify that I have answered all questions on the application and Secondary Health Questionnaire completely and accurately. I understand and agree to the release of information for the purpose (s) described above in this document.

~~By signing, I agree that I have fully read this entire application, and I understand and agree with all statements contained herein:~~

All listed applicants 18 years of age and older must agree to the terms of this authorization by signing below.

	Signature Required:	Printed Name:	Date:
Applicant			
Applicant's Spouse	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		

If your application is dated more than 60 days ~~beyond~~ before the requested effective date for coverage, a new application ~~must~~ may need to be completed.

Note: Coverage will not begin until all necessary information is received by MHP.
MHP will notify you of the approved effective date.

Applicant's Name: _____

Payment Information:

All premium payments are made either via debit ACH (automatic withdrawal) from your bank or by Credit Card*.

Please check your method of payment:

☐ Monthly Invoice – An invoice will be sent monthly to your home billing address unless a separate billing address is listed below:

Name Address (street and P.O. Box if applicable) City State Zip

☐ Automatic Bank Account Withdrawal

☐ Checking account (attach voided check below) Account # _____ Routing # _____
☐ My first payment only ☐ My first and ongoing payments ☐ My ongoing payments only (first payment made by other method)

☐ Savings Account (attach deposit slip)) Account # _____ Routing # _____
☐ My first payment only ☐ My first and ongoing payments ☐ My ongoing payments only (first payment made by other method)

I authorize Mercy Health Plans (MHP) to draft my Bank Account on the [15th][day] of each month for the amount of my monthly premium. I understand that this authorization is in effect until I notify MHP in writing that I no longer desire these services, allowing them reasonable time to act upon my notification.

Signature of Account holder	Date
X	X

☐ Credit Card

☐ VISA ☐ MasterCard ☐ American Express

Credit Card Number:	Expiration Date: _____/_____(mm/yy)

Cardholder's Name (as it appears on the card):

Cardholder's Address: City State Zip

Telephone:

☐ I authorize Mercy Health Plans to charge my credit card on the [15th][day] of each month for the amount of my monthly premium [plus a 2% administrative fee].

☐ I authorize a one-time charge to my credit card for $_____ premium [plus a 2% administration fee].

Signature of Cardholder	Date
X	X

☐ NEW LIST BILL – Billing through a third-party (This option must have prior approval and requires separate List Bill forms to be completed and submitted with this application).

☐ CHANGE TO EXISTING LIST BILL

Note: You may be charged an additional fee for insufficient funds or incorrect banking information

Attach Voided Check Here

HEALTH QUESTIONNAIRE GOES HERE. (no redline available)